



**OFFICE OF PROFESSIONAL LICENSING**  
**Board of Hearing Care Providers**

121 South Fruit Street, CONCORD, NH 03301  
Tel. (603) 271-9482 Fax (603) 271-6702

**SUPERVISED PRACTICE PLAN  
FOR HEARING CARE PROVIDERS**

**TO BE COMPLETED BY APPLICANT**

**General Information:**

Name: \_\_\_\_\_  
(Last) (First) (Middle Initial)

Address: \_\_\_\_\_  
\_\_\_\_\_

Telephone Business (\_\_\_\_) \_\_\_\_\_ Home(\_\_\_\_) \_\_\_\_\_

Date of Birth: \_\_\_\_\_ E-mail address: \_\_\_\_\_

**Training Program Responsibilities:** The supervising trainer shall, prior to its implementation, submit to the Board a plan that includes training to develop and demonstrate competency in:

Hearing Testing and Interpretation;

Otoscopic Ear Examination;

Earmold Impression Procedures;

Hearing Aid Selection and Fitting Protocol;

Hearing Aid Troubleshooting and Servicing;

**Employment Information::**

Employer \_\_\_\_\_  
(company name) (division or department)

Address \_\_\_\_\_  
\_\_\_\_\_

**TO BE COMPLETED BY SUPERVISOR**

Beginning date of employment \_\_\_\_\_

Date Supervised Training Program to start \_\_\_\_\_

Date Supervised Program to end \_\_\_\_\_

Average number of hours per week \_\_\_\_\_

Supervisor's Name: \_\_\_\_\_  
(last) (first) (middle initial)

Address: \_\_\_\_\_  
(street)

\_\_\_\_\_  
(city) (state) (zip code)

Telephone Business: (\_\_\_\_) \_\_\_\_\_ Home: (\_\_\_\_) \_\_\_\_\_

Registration# \_\_\_\_\_

**This Plan Must Be Completed, Signed, And Returned To The Board Office Within Thirty (30) Calendar Days Of The Start Of Your Supervised Training Program.**